



INLAND COUNTIES EMERGENCY MEDICAL AGENCY

Serving San Bernardino, Inyo, and Mono Counties

1425 South "D" Street

SAN BERNARDINO, CA 92415-0060

909-388-5823 FAX: 909-388-5825

SPECIALTY AND OPTIONAL SCOPE PROGRAM APPROVAL APPLICATION

☐ New ☐ Renewal ☐ Update

PROVIDER INFORMATION

Name: _____

Address: _____
Number & Street City State Zip

ADMINISTRATION

Name of proposed Medical Director: _____

Phone: _____ Email: _____

Name of proposed Coordinator & Title: _____

Phone: _____ Email: _____

PROGRAM DETAILS (ICEMA Reference #6060 - Procedure Section)

Submit the following for program review:

- Complete this Application form (*This form*)
- A statement demonstrating a need for the program.
- Description of the geographic area the specialty program will be implemented in.
- A description when the program will operate (special events, 24/7) and how implemented.
- A description of how the program will interface with the EMS System and 9-1-1.
- A description of the training related to the specialty program.
- List of employees participating in the program. (*Notify ICEMA within 10 days of any changes*)
- A detailed description of any deviation from the Standard Drug & Equipment list? Provide detail of how equipment and drugs will be transported and stored.
- A Quality Improvement plan and process for reporting any deviations.

Additional items may be required

Type of Program (Please Check)

- ☐ Mobile Medic (*bicycle, motorcycle, ATV, boat, etc.*)
- ☐ Tactical Medicine Program
- ☐ Other Specialty Program (*specify*) _____
- ☐ Optional Scope Program (*specify*) _____

Additional requirements for Mobile Medics

- A statement indicating compliance with DMV required personal safety equipment.
- A list of the type of vehicles utilized.
- Type of PCR utilized and process for transfer in the field.
- Type of communication equipment.

Completed by (Print Name): _____

Signature & Date: _____

ICEMA Use Only

Date _____
Rcvd: _____ All requirements verified: _____ Approved by: _____ Date: _____